

Whole Person Integrated Care Health Commission Update

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March 15, 2022

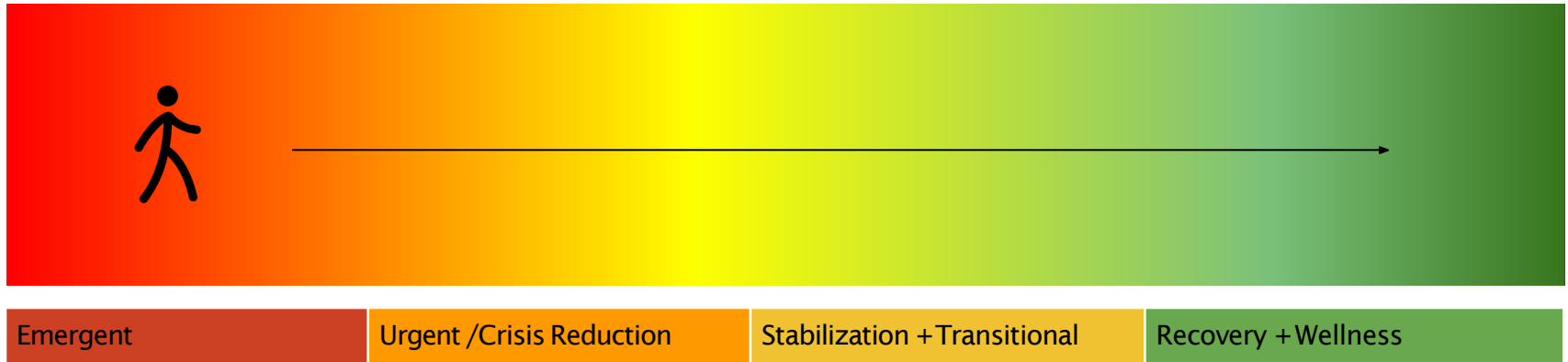


SF Department of Public Health
Whole Person Integrated Care

Whole Person Integrated Care (WPIC) is a newly formed section of the SF Department of Public Health's Ambulatory Care division that brings together existing non-traditional primary care, urgent care, and behavioral health clinical services primarily serving people experiencing homelessness.

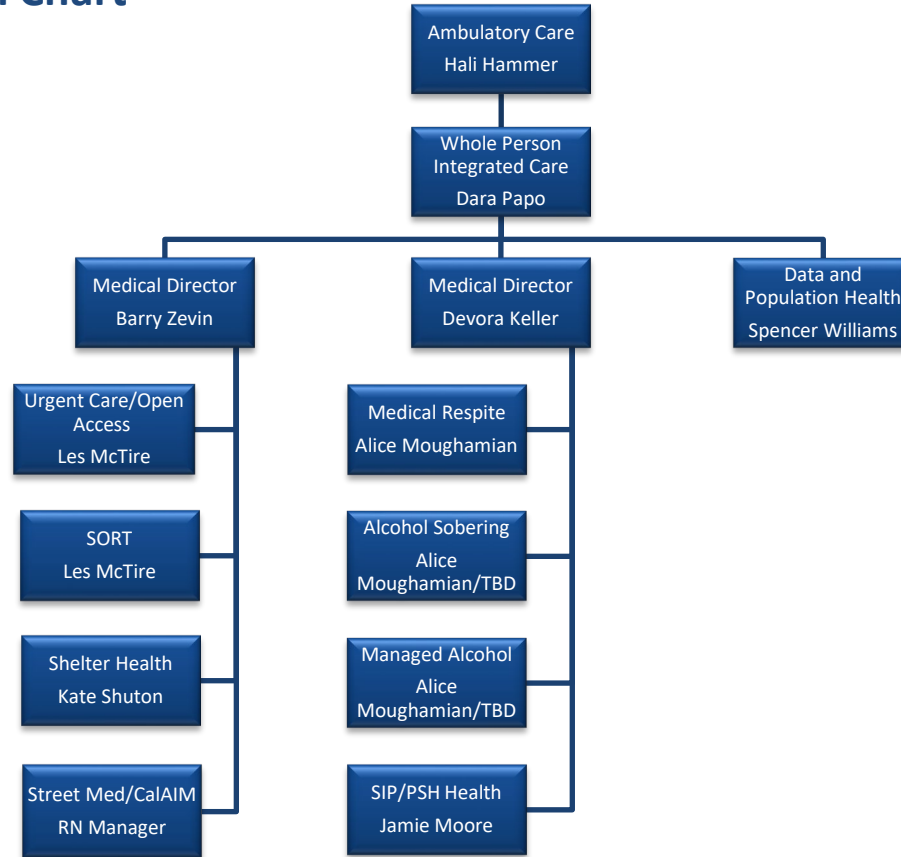
WPIC takes a data-driven, collaborative approach to caring for our highest risk patients and facilitating citywide care coordination.

WPIC services are part of San Francisco Health Network's homeless System of Care which includes specialty behavioral health services, acute and emergency services at ZSFG, and long-term care at Laguna Honda Hospital.



WPIC Organizational Chart

March 2022



Whole Person Integrated Care Programs

Street Medicine

Street-based low-barrier outreach, engagement, and care for unsheltered people experiencing homelessness.

Sobering Center

A place for people intoxicated on alcohol to safely sober off the streets, out of the emergency department and out of the jail.

Whole Person Care

Interagency collaboration and data sharing and population-based monitoring in support of “making the system do the backflips and not the client.”

Shelter Health

Healthcare teams located in shelters, navigation centers, and SIP hotels to address health issues and provide connections to ongoing care.

Open Access Clinic

Low barrier clinic providing patient-centered transitional primary care for high risk/high vulnerability people experiencing homelessness not getting their needs met elsewhere.

WPIC Urgent Care

Low barrier health care for urgent issues, full assessment for needs and vulnerability, and connections to ongoing care.

PSH Nursing

Nurse case management within select permanent supportive housing buildings to help stabilize residents and provide chronic disease management.

Medical Respite

Post-acute recuperative care for people experiencing homelessness who are too sick to navigate the streets or the shelter system, but not sick enough to be in the hospital.

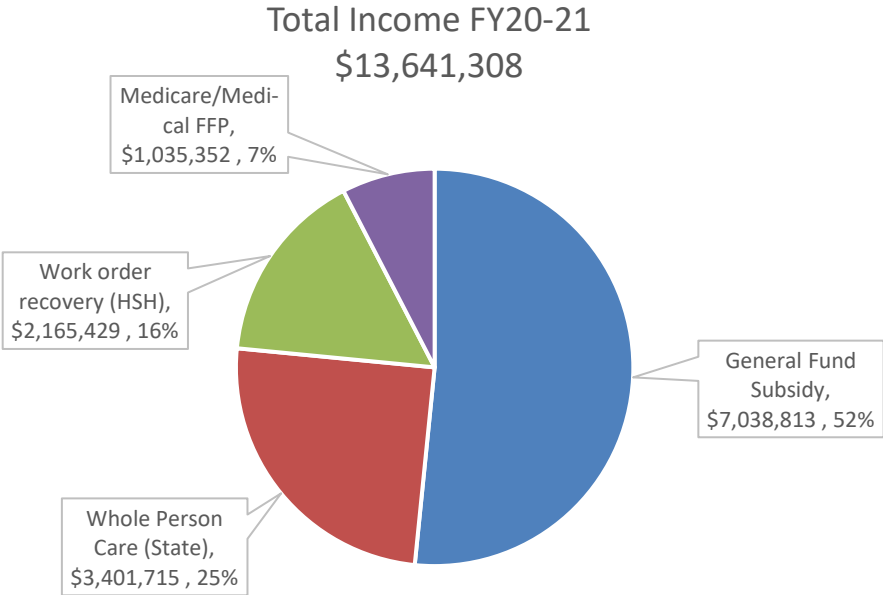
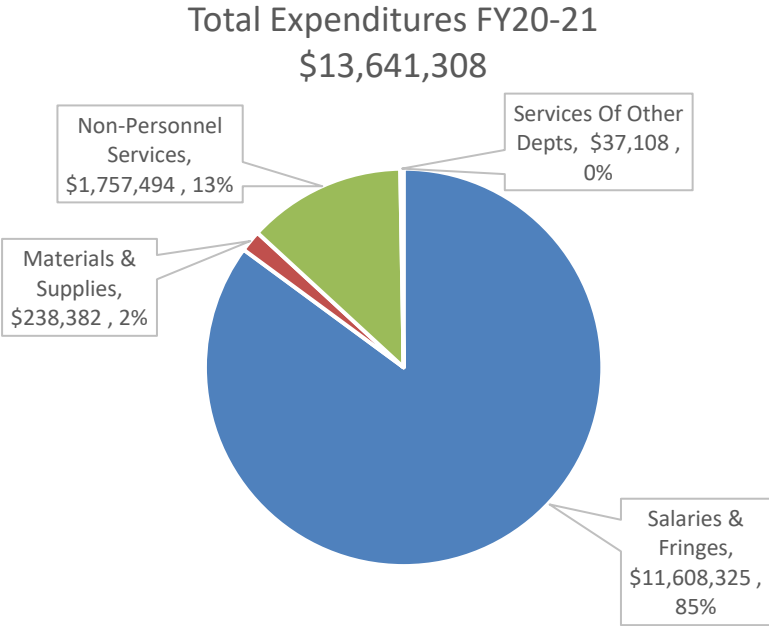
WPIC Data 2020-2021

WPIC Clients and Encounters 2020, 2021

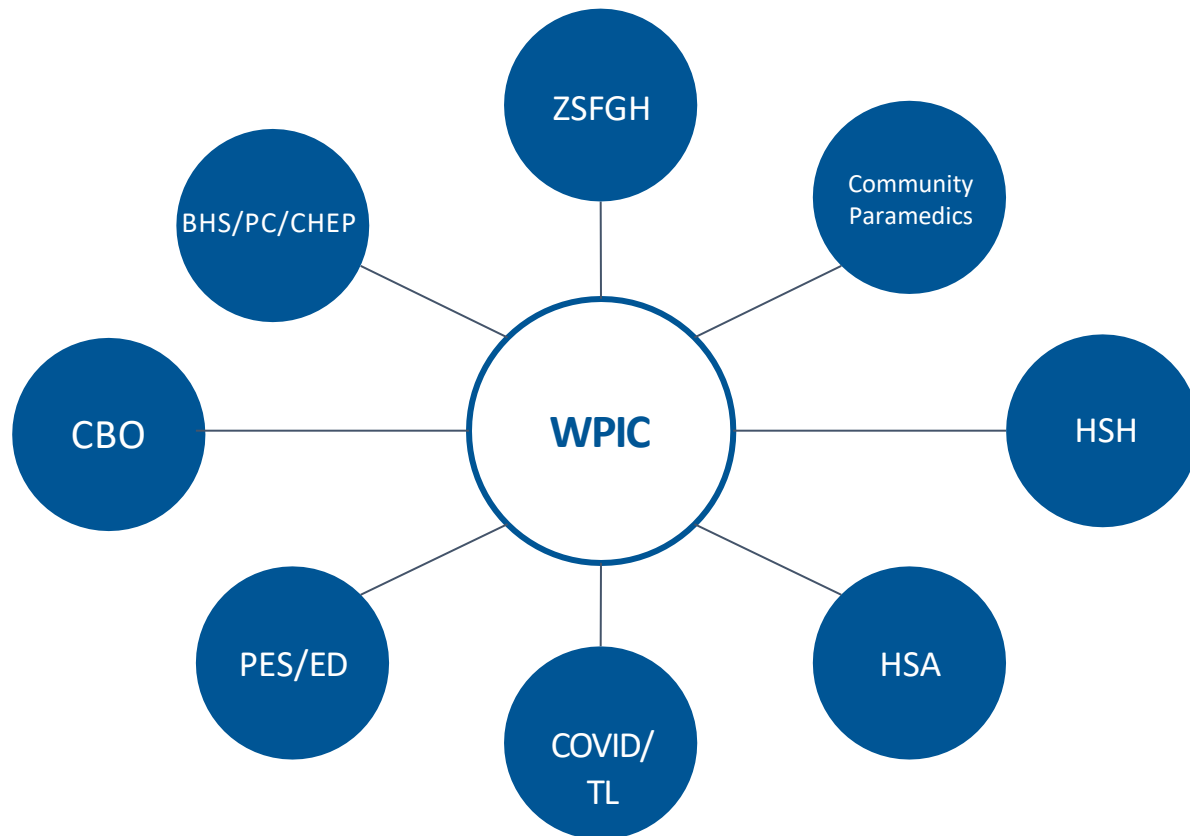
WPIC Dept	Distinct Clients		Encounters*	
	2020	2021	2020	2021
Medical Respite	400	319	7,104	6,582
Sobering Center	466	382	2,388	1,482
PSH Nursing	419	401	759	872
Shelter Health	1,489	753	5,159	2,135
Street Medicine	4,068	3,870	20,528	21,514
TW Urgent Care	3,164	4,091	7,869	14,459
Total	7,244	7,576	43,807	47,044

**Encounters include Traditional face-to-face encounter types (Clinical Support, Immunization, Office Visit, Social Work, Telehealth) plus Documentation, Clinical Documentation Only, and Patient Outreach encounters.*

WPIC Budget FY 20-21



Our Partners



New to WPIC

Programs: COVID Health Care Services for People Experiencing Homelessness (PEH)

- **Target Population:** PEH with medical, mental health, and substance use needs staying in Shelter In Place Hotels and not connected to care. PEH in WPIC services not yet fully vaccinated.
 - **Services:** Assessment of need for emergency care; episodic care for acute medical conditions and exacerbations of chronic conditions, low barrier buprenorphine. Care provided in SIP sites, vaccines provided in SIPs, congregate shelters and streets.
 - **Key partners:** WPIC programs, Behavioral Health, Department of Homelessness and Supportive Housing.
 - **What's next?:** Integration of vaccines into WPIC standard operations, evaluating SIP health care needs.
- Clinics range from ½ day to 4 days week per site
 - Staff were DSWs but are now COVID temp hires
 - Supporting guests to prepare for transition into community/PSH

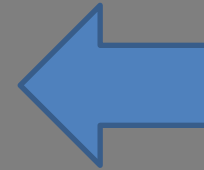


Site F - nurse making rounds to trailers



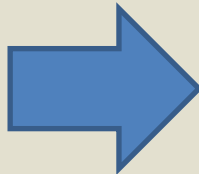
Program: Street Overdose Response Team (SORT)

- **Target Population:** Individuals who have recently survived an overdose.
 - **Services:** Community Paramedic and peer respond to 911 calls, offer resources include connections to services and low barrier medications for addiction treatment. Within 72 hours the Post Overdose Engagement Team (POEt) outreaches to continue engagement and offer connections to services and ongoing care.
 - **Key Partners:** WPIC programs, Community Paramedics, Behavioral Health, Hospitals, Community Based Organizations.
 - **What's next?:** Adding new DPH staff, peer, and harm reduction counseling services.
- Responded to over 560 individuals who experienced an overdose in the program's first six months
 - Over half were unsheltered individuals
 - 50% white, 24% Black/African American, 12% Latinx



STAFF
WORKING ON
OVERDOSE
PREVENTION

SORT TEAM MEMBERS



Program: Managed Alcohol (MAP)

- **Target Population:** Individuals with severe Alcohol Use Disorder (AUD), many of whom are frequent Sobering clients
 - **Services:** Nurse supported residential setting focused on decreasing life-threatening withdrawal seizures, emergency service utilization, and binge drinking behavior. Once individuals stabilize, multidisciplinary staff focuses on addressing biopsychosocial needs
 - **Key Partners:** Alcohol Sobering, Community Paramedics, Citywide, substance use treatment services
 - **What's next?:** Currently 10 beds, looking for a permanent location and will scale to 20 beds, with 10 focusing on Latinx and indigenous Mayan clients.
- In the first 18 months (May '20-Oct'21) served 23 clients for a total of 28 admissions
 - Diverted over 589 EMS calls
 - Saved the system over \$1.3M

SF MAP Staff



SF Department of Public Health | Whole Person Integrated Care

SF MAP Office



Thanks
For everything you did for me
You were sweeter than a honeybee
Many good things you made me see
Your help set my soul free
With Love Always [Redacted]

MAP client
thank you

Program: WPIC's CalAIM Enhanced Care Management and Community Supports

- **Target Population:** Individuals with San Francisco Medi-Cal
 - **Enhanced Care Management (ECM):** homeless/in supportive housing, mental health and substance use issues, unconnected to ongoing care.
 - **Community Supports (CS):** Medical Respite and Alcohol Sobering clients.
 - **ECM Services:** Ongoing care coordination services by a multidisciplinary team. Referrals come from Managed Care Plans (MCP).
 - **Key Partners:** WPIC programs, MCPs, Behavioral Health, Primary Care, ZSFGH, HSH, HSA.
 - **What's next?:** Services started January 2022, ramping up staffing and referrals, Sobering becoming CS July, 2022.
- CalAIM is the codification of WPC, funding services not previously funded by Medi-Cal
 - Continues WPC's work of data sharing/data integration
 - ECM services follow the client/cross systems

Program: WPIC's All Love

- **Target Population:** PEH who identify as women, trans, and non-binary and their partners, pregnant PEH, postpartum PEH.
- **Key Partners:** WPIC programs, MCAH, Behavioral Health RAMS (peers and others), Primary Care, ZSFG (Team Lily and others), HSH (SFHOT and others), PHD (CHEP, City Clinic, and others).
- **What's next?:** Expanding outreach to harm reduction programs supporting sex worker population, expanding integration in work with pregnant people, Expanding care coordination and treatment for HIV, hepatitis.

~70% PEH population is cis men but other populations have disproportionate burden of syndemic problems of HIV, STIs, poor pregnancy outcomes etc.

New Federal funding through Ending the HIV Epidemic (ETE)

Program: Permanent Housing Advanced Clinical Services (PHACS)

- **Target Population:** Serves previously chronically homeless individuals housed in SRO/studio apartment style PSH. Residents are medically and psychiatrically complex and are often High Users of Multiple Systems, end of life, and/or not connected to care.
 - **Services:** CBO capacity building consultation, triage, linkages, chronic care management, medication adherence support, direct nursing/medical care.
 - **Key Partners:** HSH funded housing providers, Behavioral Health/Office of Coordinated Care, Human Services Agency.
 - **What's next?:** Moving from pilot to launching services covering the 8,000+ PSH tenants who don't have health services in their building, adding in capacity-building and behavioral health.
- Funded by Prop C, will draw down CalAIM (Medi-Cal) revenue
 - Working with Behavioral Health/HSH/HSA to address system barriers for PSH tenants
 - Will leverage Office of Coordinated Care infrastructure

Program: Maria X Martinez Health Resource Center (new home of 50 Ivy Urgent Care!)

- **Target Population:** Serves individuals experiencing homelessness and other persons needing urgent care. Homeless, high risk/vulnerability individuals not otherwise able to access needed care.
 - **Services:** Assessment and care for non-life-threatening illnesses or injury needing immediate assistance, low barrier medications for addiction treatment, transitional comprehensive primary care services, limited dental and podiatry services offered onsite.
 - **Key Partners:** Street Medicine, SFHOT, Behavioral Health/Office of Coordinated Care.
 - **What's next?:** Clinic move anticipated August, 2022.
- UC is open Monday-Saturday
 - Will continue to provide health care services for Tenderloin Linkage Center and street outreach teams

What's Next: WPIC in 2022

- New home for Sobering/MAP and possible addition of site-based Isolation and Quarantine for PEH needing on-site recuperative care.
- Integration with Behavioral Health/Mental Health SF serving PEH.
- Integration with Population Health and Disease Control activities.
- Right sizing FTEs to match program growth and build our internal infrastructure.
- Key clinical focus areas:
 - Syndemic response – treatment and prevention of HIV, HCV, STI, congenital syphilis and other poor pregnancy outcome.
 - Palliative care for PEH.
 - Low barrier care and treatment for PEH with SUDs.